IN THE SUPREME COURT OF THE UNITED STATES

AETNA HEALTH INC., FKA :
AETNA U.S. HEALTHCARE INC. :
AND AETNA U.S. HEALTHCARE :
OF NORTH TEXAS INC., :
Petitioner :
V. : No. 02-1845
JUAN DAVILA; :
:
and :
:
CIGNA HEALTHCARE OF TEXAS, :
INC., DBA CIGNA CORPORATION, :
Petitioner :
V. : No. 03-83
RUBY R. CALAD, ET AL. :

Washington, D.C.

Tuesday, March 23, 2004

The above-entitled matter came on for oral argument before the Supreme Court of the United States at 11:09 a.m.

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APPEARANCES:

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JAMES A. FELDMAN, ESQ., Assistant to the Solicitor General, Department of Justice, Washington, D.C.; on behalf of the United States, as amicus curiae, supporting petitioners.

GEORGE P. YOUNG, ESQ., Fort Worth, Texas; on behalf of the respondents.

DAVID C. MATTAX, ESQ., Assistant Attorney General, Austin, Texas; on behalf of Texas, et al., as amici curiae.

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P R O C E E D I N G

CHIEF JUSTICE REHNQUIST: We will hear argument next in number 02-1845, The Aetna Health Care v Davila and Cigna HealthCare versus Calad.

Mr. Estrada.

ORAL ARGUMENT OF MIGUEL A. ESTRADA

ON BEHALF OF THE PETITIONER

MR. ESTRADA: Thank you, Mr. Chief Justice, and may it please the Court:

The issue in these consolidated cases is whether participants and beneficiaries of ERISA plans may seek consequential and punitive damages in state court under state tort law for the allegedly wrongful denial of ERISA health care benefits. The Fifth Circuit answered that question yes, reasoning that completely -- that the complete preemption under the Federal statute applies to contract claims that essentially duplicate what's available under Section 502 of the Federal statute, but not to tort claims, which give supplemental remedy for consequential and punitive damages.

For two principal reasons, the judgment of the Fifth Circuit should be reversed. First, this Court has consistently held that all challenges to the propriety of benefit determination, whether couched in tort or in contract, are completely preempted by Section 502 and therefore are removable and governed solely by Federal law.

Second, the fact that the welfare plans at issue in these cases provide benefits for medical care, as opposed to disability, death, or some other welfare benefit, does not alter the analysis under the Federal statute or give the states any more power to supplement the remedies that Congress included in Section 502.

QUESTION: Now just to be clear, Mr. Estrada, you take the position that ERISA Section 502(a) completely preempts the Texas scheme here?

MR. ESTRADA: Yes.

QUESTION: And we don't have before us any conflict preemption under Section 514?

MR. ESTRADA: That is - that is right, Justice O'Connor. That is our position.

QUESTION: Okay.

MR. ESTRADA: And turning to Section 502(a) and to the --

QUESTION: Mr. Estrada, can I just raise a question? I'm sure you'll cover it in the argument and I want to get it on the table. On your first point, that our prior cases have said that 502 is the exclusive remedy for actions to acquire benefits, is there a distinction? Some of your opponents argued between denials based on the terms of the plan, that this just doesn't qualify for some reason, on the one hand, that you just should get the answer out of the plan, and denials based on a

discretionary decision as to whether the medical treatment was appropriate or not, which would require the exercise of some kind of professional judgment. The nurse might think he doesn't need an extra day in the hospital or something like that. Is that a valid distinction or not?

MR. ESTRADA: No. And let me turn to that -- that was my second point, but I'll turn to it now. The use of medical criteria, whether discretionary or not, is inherent in health care coverage and usually is also inherent in - - in disability coverage. Yet, last Term, in the Black & Decker case, this Court held that the -- that a claimant's treating doctor gets no special deference in a claim for the benefits where the issue is whether the medical factors warrant a disability finding. Under the theory being advanced by Texas and the respondents in this case, however, Black & Decker needn't, and maybe even couldn't, be an ERISA case because a state of the union could regulate the medical component of the disability finding under the guise of regulating the practice of medicine and could give tort remedies and consequential and punitive damages whenever the plan disagreed with the -- with the claimant's doctor.

QUESTION: Yes, of course they could, but the fact that if we held there was no preemption, it wouldn't necessarily mean they would win on the merits. I mean, you are -- your drug formulary may be absolutely defensible, even though it could be tested in a state court proceeding.

MR. ESTRADA: Well, I didn't understand the claim as to the Aetna case necessarily to be a challenge to the promulgation of the formulary, which is expressly authorized by the prescription drug writer of the plan. I understood the challenge to be to a particular benefits decision that was made when Aetna, the insurer and plan administrator, concluded that the benefit was not covered in the circumstances because of the step therapy requirement.

QUESTION: I don't want you to go too long on point two without getting back to point one, but as long as we're here, it does seem to me that the dichotomy, the duality you propose between a decision about benefits and medical treatment might, at the edges, blur into each other. If I say, as Aetna or CIGNA, you're not authorized to seek this treatment and the person has no other funds, basically, that is a treatment decision, in a sense.

MR. ESTRADA: No, it is not, Justice Kennedy. The purpose of employee benefits plan -- benefit plans is to cover some things for the employees. If the plans in these cases said that the benefit was $100 for each hospital stay or that you got $20 for your drugs, whatever they may be, no one would deny that that was a -- that that was a benefit determination. As I said earlier, with respect to medical care, it has always been the case that in determining the scope of coverage, medical factors have always been used and that factor is imbedded into the

background understandings of how this very statute works.

For example, Section 503 of the statute allows the Department of Labor to promulgate regulations to deal with how claims are made and the like. One of those regulations by -- by the Department of Labor expressly contemplates that if a claimant has a proposed treatment turned down, he may appeal to a named fiduciary who is required, under the DOL regs, to consult with an -- with an appropriate medical hair -- care professional and --

QUESTION: I guess my point was, at some time, and even in these cases, there -- that there was a component of what we might call medical judgment involved.

MR. ESTRADA: That is undisputed, Justice Kennedy, and I think that our position is that there is a fundamental difference between a claimant who has a doctor patient relationship with his doctor and a claimant who had an insuretal coverage relation with his insurer. Just to put it into context of legal practice, if the person reading the plan documents and denying a claim -- the claim, excuse me, uses medical training to conclude that the plan documents did not cover a treatment, I think few people would think that that entitled the claimant to sue the person who turned it down for legal malpractice.

And the same is basically true here, too, because the plan's -- the plan's role, as is very clear in the express, for example, in the -- in the text of the Monitronics opinion, is to deal with the question, shall we pay or shall we not pay. And

that's actually precisely what Texas has targeted here.

If I could direct the Court's attention to the petition appendix in the Aetna case, 02-1885, the relevant parts of the Texas statute are set forth in page 59a and --

QUESTION: 59a of what?

MR. ESTRADA: Of the Aetna petition appendix, 02-1885, Mr. Chief Justice. And as -- and there are three that are relevant here. Two of them are on page 59 and one of them is on 58a.

The first one that I want to point out is close to the top of the page. It is an affirmative defense under the Texas statute that the managed care entity did not deny or delay payment. This is not about treatment. It is a defense that it did not deny or delay payment. And of course delay may be a bid for - of what a -- of what the role of the administrator is.

The second aspect of the statute is that the statute makes very clear, once again on page 59a, that the managed -- that the liability -- oh. This is subsection d, Mr. Chief Justice, which is the next following --

QUESTION: Oh.

MR. ESTRADA: -- you know, the one that I read. And it says the act creates no obligation on the part of the health insurance carrier, moving down a little, to cover a -- to provide a treatment which is not -- which is not covered by the health care plan or entity. Once again, this is targeting the coverage

aspect, not the treatment.

QUESTION: Yes, but let me just focus on the case involving the woman who may have needed a second day in the hospital. Is it correct that they -- an agent of the HMO had discretion to grant that second day if the nurse thought it was really medically required?

MR. ESTRADA: I don't -- I don't know if there's anything in the record about that. What is clear from the record and from Federal law, Justice Stevens, is that somebody in the plan would have discretion to hear her appeal, even if the nurse that -- that turned the request down --

QUESTION: So the decision as to whether she would have the second day in the hospital would depend on a medical judgment made by an agent of the plan. Is that corrèct?

MR. ESTRADA: It would -- it would ultimately -- it would ultimately turn on -- on a coverage decision that may include medical criteria.

QUESTION: But the coverage is if it's medically needed, it would -- she would get the second day. But whether or not it's covered then turns on a medical judgment, does it not?

MR. ESTRADA: But the question of medical necessity is a coverage term. It is not a medical term, Justice Stevens, and --

QUESTION: Yes, but is not correct, to make the coverage decision, one has to make a medical decision?

MR. ESTRADA: It -- one has to make -- one part of the coverage decision is the medical decision. In the Aetna case, for example, the plan sets forth a definition of medical necessity which -- which sets forth, I do point out, is that you have to need it -- to need the care --

QUESTION: Well, I was focusing on the CIGNA case, because it seemed to me that it's a little clearer there that there would be a medical judgment required.

MR. ESTRADA: Well, once again, Justice Stevens, we do not contend that health insurance does not involve the consideration of medical factors. And, as I said, it is almost inherent in the nature of the product that it would, just as I never had car insurance before I actually owned a car.

QUESTION: But it's a little -- it's a little like -- if you're telling doctors what's medically necessary under the plan, it's in effect maybe defining the basic standards of medical care, in a way.

MR. ESTRADA: That is not right, Justice O'Connor, for the following reason. The plan documents here, and the background understanding of all of the parties, is that it is for the treating doctor to chart the course of treatment for the patient and, in fact, under the AMA's old code of ethics, which we cite on page 6 of the Aetna reply brief, a physician is not allowed to sway his judgment as to treatment by the existence or non-existence of coverage. In many cases, unfortunately, there

will be people who have no coverage or no insurance, or may be under-insured.

But just to bring back the case to what the statute is about, this statue is about encouraging employers to make hard choices to give coverage to employees to the extent they can. There is no requirement in Federal law that requires employers to give -- there are very few requirements in Federal law that require employers to give particular benefits if they choose to have a plan. And, as this Court has said, most recently in the Rush case, this is about a bargain with employers that seeks to encourage the formation of these plans and the provision of benefits to the extent possible by assuring employers of limited liabilities under predictable standards.

QUESTION: If you are correct that Section 502(a) preempts, is it possible that under ERISA 502(a)(3), that the plaintiffs might recover some money, for example, for pain and suffering and things like that?

MR. ESTRADA: I would think not, Justice O'Connor. Our amicus, the Department of Labor, may take a slightly different view of that. Our reading of the Mertens case and the Great West case, which seemed very clearly, to us, at least, to stand for the proposition that equitable is to be determined by reference to an historical examination of all that is available in equity --

QUESTION: Yes, but if you make an analogy to a trustee

in equity, I think this is a different case than Mertens or Great West, because here, let's see, Aetna and CIGNA are fiduciaries, are they not?

MR. ESTRADA: Aetna is -- and CIGNA is for purposes of claims processing.

QUESTION: Yes. And so, as a fiduciary they're -- they are analogous to a trustee, at least, the government said, if I read their footnote 13 right, that back in the old days when there was -- was a division of the bench, that one of the remedies available against a trustee would be in the nature of make whole relief that would put the beneficiary in the position he would have been in if the trustee had not committed the breach of trust.

MR. ESTRADA: That was the view to which I refer earlier, Justice Ginsberg, and it is possible that it may be right. It seems to me, based on Great West and Mertens, that it would be a tough case to make, but it is not the issue in this case. Now --

QUESTION: No, but the whole thing would work if we could do that, wouldn't it? I mean, if we could get Mertens consistent with what Justice Ginsberg just read, then you would provide people who are hurt, in the way these plaintiffs were hurt, with a remedy. It wouldn't be punitive damages, but they would be made whole. So, if you are right in that this is basically a -- this is basically a claims decision and you

shouldn't give punitives and others for the incorrect making of a claims decision. But the hole in this is that then the woman gets nothing or virtually nothing and, if we could reconsider that part, it would all work, wouldn't it?

MR. ESTRADA: Well, it might, but it also works in the way it currently is for the following reason. The interaction of the structure of Section 502 and Section 503 is intended to set forth a mechanism, under the DOL regs under Section 503, to encourage the expedis -- the expeditious resolution of claims disagreements. And this is -- the statute contemplates litigation but is not about litigation. This is all about giving the benefit when it is needed and not about waiting until it no longer helps you, having bypassed all avenues you had at the time, external review, plan appeals, or maybe an action for an injunction and then suing for relief, make whole or otherwise.

If I could, Mr. Chief Justice, I would like to reserve the remainder of my time.

CHIEF JUSTICE REHNQUIST: Very well, Mr. Estrada.

Mr. Feldman, we'll hear from you.

ORAL ARGUMENT OF JAMES A FELDMAN

FOR UNITED STATES, AS

AMICUS CURIAE

QUESTION: Mr. Feldman, will you tell us what the government thinks can be recovered under 502(a)(3) in the way of damages or other recovery?

MR. FELDMAN: Yes. As Justice Gin -- as Justice Ginsberg said, our position, I think, is in footnote 13 of our brief, and it's a position the Department of Labor has taken in cases and number --

QUESTION: Pretty big point to be in a footnote.

MR. FELDMAN: Well, it's -- it really isn't the issue in this case because our position in this case is that the claims are preempted by 502(a)(1)(B). But, in a case where there was a fiduciary involved, in the days of the divided bench, when a beneficiary sued a fiduciary, they weren't -- they couldn't -- weren't able to get make whole relief. And the -- by the same --

QUESTION: Lest we be too sanguine about the application of that law in this context, I don't know any equitable cases that would consider make whòle relief to be giving -- where what is at issue is merely the payment -- the failure to pay money, refusal to pay money. Make whole relief would give you what you would have done with that money if you had gotten it. That's very strange.

MR. FELDMAN: You get -- there were -- there are cases that I -- I don't want to get too deeply into 502(a)(3)(B), because I don't think it's what's at issue in this case. But there are cases in which, for example, a trustee doesn't buy an insurance policy that they're supposed to buy and then the beneficiary can get, as relief, whatever the value of that insurance policy would have been and --

QUESTION: Sure. But all that's going on here is that the claimant was perfectly able to buy Vioxx with his own money, but when it was said by the insurer that they wouldn't pay for Vioxx, the claimant went and -- went with the drug that was covered. I have serious doubts whether we can take comfort in the fact that even if we deny relief here it'll all be okay because under traditional equity law, in a situation like that, you can -- you can get whatever you would have done had you been given the money. I don't know that that principle washes.

MR. FELDMAN: Well, 502(a)(3) -- I mean, ERISA does head up a beneficiary trustee -- a beneficiary fiduciary type of relationship that does have analogies in traditional equity. But in any event --

QUESTION: And the government has taken position -- this is -- the footnote is not the easiest to read, but I take it the Department of Labor has taken the position, in some ERISA cases, that there would be just the kind of relief that Justice Scalia mentioned. Would this case fit that pattern?

MR. FELDMAN: I -- it's not clear to me whether it would, because it's not clear to me whether there was a fiduciary involved in this case. Neither of the claimants in this case, neither they -- the people who denied the benefits on behalf of the plans may or may not have been fiduciaries.

QUESTION: But, as Mr. Estrada just told us that, for these purposes, both Aetna and CIGNA would be fiduciaries.

MR. FELDMAN: They -- well, whether the -- you know, I frankly haven't thought about whether the plan itself would be a fiduciary. Ordinarily, the way the ERISA scheme is supposed to work is, if you have a denial of benefit, you have a right to appeal to an appropriate named fiduciary, and at that stage, departmental regulations give you kind of very substantial procedural rights to make sure that benefits determination gets made very quickly and appropriately, in light of the medical exigencies of the case.

QUESTION: I would like to hear your arguments on the preemption issue.

MR. FELDMAN: Thank you. Our argument is that the Texas law provides an additional remedy to that in Section 502(a)(1)(B), because respondents' right to recover compensatory and punitive damages in this case depends on their showing that they had a right to the benefits under the plan -- under the terms of their plan. The state law provides that plaintiffs must prove that the plan's failure to exercise what the state law says is due care, that their failure to exercise due care is the proximate cause of the plaintiff's injury. The only way that that could be true is if the plan didn't pay benefits that it was obligated to pay under the terms of the plan. The plan --

QUESTION: Yes, but in the situation in the hospital case, there was no time to get relief. How could they -- how could they get relief from the denial of the extra day in the

hospital between midnight and the next morning?

MR. FELDMAN: Well, I -- in the first place, she was told before -- I think the complaint says she was told before she entered the hospital that she would have only one day in the hospital. But in addition --

QUESTION: Unless it was medically necessary to stay an extra day.

MR. FELDMAN: Right. And I would just say there's about three backstops there. One is Department of Labor regulations say you have to make determ -- these determinations as soon as possible considering the medical exigencies of the case and she didn't --

QUESTION: And what does that mean in the hospital setting? And what -- was she going to file a complaint with the Department of Labor?

MR. FELDMAN: These claims can be made orally, again, if the exigencies require, and she could -- she didn't try -- as far as we know, no one made a phone call to the insurer and said can I get the extra benefits; she needs it. We don't know what the results of that would have been.

QUESTION: Well let's assume the case -- because your preemption item would cover even the most extreme case. Assume the case in which the patient and the doctor both called the agency and appealed and they said we're too busy, we can't handle it and it later determines they were -- did not exercise due

care.

MR. FELDMAN: But then --

QUESTION: Why are you preempting the state providing a remedy for that situation?

MR. FELDMAN: That would have been itself a denial of their obligations under the Department's claim processing -- claims processing procedures. But let me say there's also --

QUESTION: It would have been a denial, but it wouldn't have given her the extra day in the hospital?

MR. FELDMAN: Right, but there are other backstops for her getting the extra day in the hospital. She is, at that point, in the same position as anyone else who can't pay for another day in the hospital but they need it.

QUESTION: I understand.

MR. FELDMAN: It's up to her doctor, with whom she has a doctor patient relationship that's a consensual relationship for providing medical treatment. It's up to her doctor to decide when she should be discharged from the hospital and when she shouldn't.

QUESTION: But she can't --

QUESTION: But the question we really are facing is whether the State of Texas is denied the authority to provide a remedy in that situation.

MR. FELDMAN: Yeah, but the State of Texas has many remedies to make sure the hospitals don't discharge people who

need an extra day in the hospital and medical ethics provides additional reasons why doctors have -- cannot discharge patients who need an extra day in the hospital.

QUESTION: I take it you -- the drug case, the man couldn't pay for the more expensive drugs. He didn't have the means and so he took the drugs that the HMO approved with disastrous results. There was no -- window -- there was no time. He was in intense pain. He had to take something to deal with the pain.

MR. FELDMAN: There was -- he took the drug, I think that -- the record actually shows, I think, that he took the drug for several weeks before he had -- before he had the problem with it. He could have been pursuing the plan remedies all throughout that. In addition, Texas law, like the law of 44 other states, provides for an independent review mechanism which is also designed to decide at the front end whether -- what benefits you're entitled to. And under that mechanism he could have sought independent review from somebody who's independent of the plan, not subject to any bad incentives he might have thought the plan might have, to make an accurate determination of what is -- what he's entitled to and what he's not entitled to.

It's -- there are -- there are a number of remedies that people can -- that people have in order to make sure they stay in the hospital. What the ERISA plan is doing here is simply making a benefits determination. It's a pure

determination under ERISA and it's not based on the formation of a doctor patient relationship which the patient has with their doctor. It's based on their determinations under ERISA, under Section 502(a)(1)(A) -- Section 502 of ERISA, Congress drew a very careful balance between the needs for a prompt and quick claims processing procedure that would be effective and to decide in advance whether you get benefits and the public interest in encouraging the formation of employee benefits plans and encouraging the provision of benefits under those plans.

To allow states to essentially say, as the state has said here, well, we're going to provide an additional remedy that Congress rejected when it drew that careful balance, would be an -- as the Court said in Pilot Life, to completely undermine Congress's decisions about how this system should be structured. The state has ample authority to address medical malpractice in the state in between -- between doctors and patients where that doc -- consensual doctor patient relationship has been formed. What it doesn't have authority to do is to take its -- that medical malpractice law and extend it, not to the normal doctor patient situation, but to a situation that is governed by Federal law under Section 502 and by the remedies that Congress chose where appropriate.

QUESTION: Is there any indication in the record whether these individuals did not have the funds to stay in the hospital another day or to buy Vioxx?

MR. FELDMAN: There's -- I don't think there's any indication of whether they did or not. And, in fact, I don't -- I think that under the co-payment of the Aetna plan, Vioxx wouldn't have been terribly expensive because Aetna would have picked up some of tab for that. But all of those would be facts relating what's in the plan. I think they all just point out that the question in this case is what the plan provided and did the plaintiffs get what the plan provided. And this Court decided, in Pilot Life and in Metropolitan Life against Taylor, and it reaffirmed two terms ago in the Rush Prudential case, that those questions are ERISA questions and Congress decided that -- set in place a set of remedies that allow for very substantial rights to determine whether you're entitled to the benefit, but limited your rights to sue for pun -- for còmpensatory and especially punitive damages afterwards, because there's also, on the other side of the balance, the need to encourage employers to provide healthcare and to create ERISA plans.

And, as I said, to allow states to interfere in that balance and, as Texas has done here, to create a cause of action which is essentially for the denial of a plan benefit, and that's something that the plaintiffs, I think, have to prove in order to prevail, is to directly interfere with that decision of Congress.

QUESTION: But isn't that correct that those cases did not involve treatment decisions, Pilot Life and Metropolitan?

MR. FELDMAN: Those cases involved disability

insurance, but they were -- they had a medical element in those -- in those decisions. That's --

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Feldman.

MR. FELDMAN: Thank you.

CHIEF JUSTICE REHNQUIST: Mr. Young, we'll hear from you.

ORAL ARGUMENT OF GEORGE P. YOUNG

ON BEHALF OF THE RESPONDENTS

MR. YOUNG: Mr. Chief Justice, may it please the Court:

I'm going to focus on the narrow Federal jurisdictional issue because this case -- these two cases come to the Court based on the Federal removal doctrine that goes under the rubric of complete preemption. In each of this Court's cases on complete preemption, the plaintiff's cause of action, while not citing to the Federal statute, almost exactly duplicated the Federal remedy. Here we don't have that.

Here, what Texas has done is to fill a vacuum and say we are going to set out a professional medical standard of care when HMOs make medical necessity decisions. Under the HMO's position, they would be free to say we're going to use the medical necessity standard of a witch doctor or whatever we decide it is on today's basis without any reference to objective medical standards. Now, their medical necessity statement doesn't say that, but under their argument today, they would be free to do that.

QUESTION: What do you mean free to do it? They would be subject to -- to an appeal and an appeal to an independent authority.

MR. YOUNG: Yes, Your Honor. They -- yes, Justice.

QUESTION: And if they didn't pay up, they would be -- would be liable for damages.

MR. YOUNG: If there is time for an appeal and if the circumstances would permit an appeal. An appeal is a great thing in these cases. Independent review is a great thing --

QUESTION: No. What I'm -- I'm just speaking to your point of whether they're Scott free to do whatever they want. They surely aren't, you know. Even if the appeal comes afterwards, the claimant can get the money that's owed and the relief provided by 502(a).

MR. YOUNG: But, Justice Scalia, in these two cases, the patients did what the HMO wanted and when, under their argument, if the patients do what the HMO wants and it turns out those were bad medical decisions, there is no remedy. ERISA --

QUESTIONS: They don't do what the HMO -- all the HMO said is, look, under the plan, as we understand it and as we judge medical necessity, we don't have to pay for Vioxx. Now, if you want to have Vioxx, buy it yourself, and I gather there was some co-payment that would have been given, and if their doctor thought that Vioxx was really essential, surely the doctor would have abided, you know, pony up the money.

MR. YOUNG: Well --

QUESTION: But to say that the plan condemned them to not using Vioxx is simply not true. All you're talking about here is money. The claimant didn't want to lay out the additional money for the Vioxx.

MR. YOUNG: Well, the truth is, Your Honor, that neither of these claimants would have needed health insurance if they had the independent means to just whip out gold card and pay for the drug.

QUESTION: See, that's why I'm thinking that Vioxx is not that -- you know, on your argument you were just making, and I'll only lead you into this red herring once.

MR. YOUNG: Okay.

QUESTION: But it would all work, you see, if I have a trust, the trust is supposed to buy me an insurance policy, and through total fault of the trust it doesn't, and the house burns down, the equitable relief appropriate would be consequential damages of the value of the house. Now, if that were an appropriate case, other equitable relief, this whole thing would work and you wouldn't be having to fill a vacuum.

MR. YOUNG: But under this Court's opinions previously under 502, that remedy and those kinds of relief are not available.

QUESTION: So you see then the logical point where I'm -- I'd like to say modify those perhaps, but, well, the very fact

that you're trying to fill this hole here proves the point, because if there is a hole, it's because the court has interpreted this statute perhaps wrongly as the Federal relief being A, B, and C. Maybe it should be A, B, C, and D, and so what the state's trying to do here, is add D. And the one thing they can't do, is add D to A, B, and C.

MR. YOUNG: It's true, Your Honor, that there is this whole, but that is not the reason that we should prevail on this narrow jurisdictional issue, because it's the source of the duty. The duty that arises here is not based on what is in the plan document on medical necessity. It comes from the external duty that is imposed by Texas statute to meet the professional medical standard of care.

QUESTION: Well, how different is the question of the merits here, whether you should prevail and the question of complete preemption which is raised in the removal issue?

MR. YOUNG: Mr. Chief Justice they are different. Because, in this narrow issue, the complete preemption issue, especially when one looks at Pilot Life and Taylor. Those two decisions relied very heavily on section 301 cases, the Labor Management Relations Act cases. But if you look at those cases since Pilot Life and Taylor, every time the duty arose from something separate than the collective bargaining agreement, every time this Court has said that there is no complete preemption.

QUESTION: So your view is you could prevail on the propriety of removal, because there's not complete preemption, and yet go back and lose on the issue of whether your claim is in fact preempted?

MR. YOUNG: Yes Your Honor, that is the way complete versus conflict preemption can work and the way that this Circuit said it could work. Now I want to be clear, we don't think that we lose on Section 515 preemption either. And in fact every time this Court has gone through an ERISA analysis and found Section 502 preemption, every time, it first goes to through the Section 514 step. Now that brings me to something that may be sensitive in light of one of the opinions issued today. But I want to talk a little bit about the insurance savings clause under Section 514, because it's very important. This Court, in Rush Prudential said, that when a state regulates medical necessity, as Texas does here, that falls within the insurance saving clause. Clearly this statute falls withing the insurance saving clause, especially as applied in these two cases.

QUESTION: Well that's contrary to Pilot Life, isn't it?

MR. YOUNG: No, Your Honor, and for this reason. While Pilot Life has a statement in there, that -- a very definite statement, that 502, might trump and probably according to Pilot Life could trump the insurance saving clause, the Court also found very clearly that the insurance saving clause was not met in that case. And this Court has never faced what this Court,

the majority in Rush Prudential called the forced choice, between an insurance saving clause and Section 502. And it's very important to look at the plain text of Section 514. Because Section 514 (b) the insurance saving clause, says very clearly nothing in this sub-chapter can be construed to preempt.

QUESTION: The strangeness of your argument is that you said all right, Pilot Life faced that issue, and says the savings clause doesn't apply in the complete preemption situation. Your argument is that in effect by defining the -- the benefit -- by Texas' act of trying to define the benefit denial as equivalent to the practice of medicine, it therefore gets us back into the insurance savings clause. It seems to me an irrational logical leap. 502 says we get out of the insurance savings clause because of complete preemption, Texas says by saying what you're really doing in denialing -- denying a benefit, is practicing medicine. We get back into the business of insurance, and the insurance savings clause applies. I just can't follow that.

MR. YOUNG: Your Honor, the confusion arises because we don't write -- we don't write the terms of the HMO's coverage if you will. They're the ones that say, in determining what we will pay for, if you will, we are going to make medical decisions.

QUESTION: Well they're the ones that --

MR. YOUNG: They're the ones that can --

QUESTION: is there any insurer that does not at some point incorporate some issue of medical judgement in it's

coverage?

MR. YOUNG: Yes.

QUESTION: If it does not, then in effect it is giving carte blanche to any medical decision by a doctor without right of review.

MR. YOUNG: Yes, Your Honor, in fact, some HMO's in the last two or three years have abolished this second guessing of the physician, this medical necessity step.

QUESTION: But let's -- but suppose they don't, do the agents of the insurers who make these determinations do they have to be admitted to the practice of medicine in Texas?

MR. YOUNG: Not in Texas, but they have to be medical professionals according to the Texas statute. And the Texas statute says, when you make these deci --

QUESTION: What is a medical professional?

MR. YOUNG: Well, in the case of a nurse, nursing judgment. In the case of a --

QUESTION: But they don't have to be doctors?

MR. YOUNG: They do if they're making a medical decision that a doctor would make. Under Texas law they do, and they're held to that standard. And that's all we're doing here. Is we're holding them to that medical standard.

ERISA says nothing, Justice Scalia, about what standard the HMO's or deciders have to meet.

QUESTION: But you talk about the standard of care, but

they're not giving care. They're giving out money.

MR. YOUNG: Your Honor.

QUESTION: They're not giving care at all, the caregiver was the individual's doctor who said stay in another day or take Vioxx. They care -- all this company was doing was looking at the contract, do we owe any money.

MR. YOUNG: Justice Scalia --

QUESTION: That's not giving care.

MR. YOUNG: Justice Scalia I think it would be very helpful to look at when a payment decision could be made and when it is made in these cases. You start an episode of care here, you finish it. The bill comes due to make the payment. Here the HMOs don't wait until the bill comes due to make the payment decision. They make the decision as part of a medical necessity determination, in here, earlier in the middle, concurrent review, or prospective review is the technical term.

QUESTION: But it's a decision to pay money?

MR. YOUNG: It is a decision that may --

QUESTION: Or not to pay money?

MR. YOUNG: Not exactly Your Honor, because it is a decision that could result in not paying money, but it is first foremost done here, or here to influence the medical decision --

QUESTION: It's both. It's both and the trouble with it is, if you -- you could have marvelous laws in Texas governing pension trustee behavior, governing all trustee behavior. But

Congress says well you can't apply your marvelous rules to ERISA plan trustees. And now it seems to have said, and you can't apply your marvelous medical rules, even to a doctor, where what the doctor is doing in that instance is not acting as a doctor for treating the patient, but rather acting as a determiner of whether he will get the ERISA plan payment. And what we have in your case I guess is a person who does both. He does something of both. But where they are inextricably mixed and where there is a very large share of making the benefit determination, is it fair to say that Congress would have wanted the Texas law to apply?

MR. YOUNG: Yes, because of Pegram, this court in Pegram said very clearly --

QUESTION: In Pegram you were dealing with the doctor who was the treating physician, that is precisely what Justice Bryer has just defined as not being the case here.

MR. YOUNG: Your Honor, in Pegram this court said -- the majority said there's no basis to distinguish an HMO where the decision's made --

QUESTION: When we were dealing with a treating physician, we're not dealing with a treating physician here.

MR. YOUNG: But here Your Honor, you're dealing with a medical judgment that's not made at the end when the bill comes due, it's made early on with the sole purpose of influencing the medical treatment, the course of treatment. If this were only

about payment --

QUESTION: Why do you say that? I don't think AETNA cares whether this individual took Vioxx, or whether this patient stayed in the hospital for another day. I don't think AETNA cared a bit. All AETNA cared about was whether it had to pay for it.

MR. YOUNG: Justice Scalia, if that were true then they would make these decisions at the end. Because by shifting --

QUESTION: It's important to the patient to know. Because the patient when -- when the patient finds out that if you take Vioxx, you'll have to pay for it yourself, the patient can then ask the doctor, look doc, is it really important that I take Vioxx or is this other stuff in your judgment as the treating physician, is this other stuff good or not -- good enough. It seems to me you want that decision to be made early.

MR. YOUNG: Well, the truth is that making the decision here shifts the risk. If it's made at the back end the risk is shifted to the pharmacy, or the doctor, or the hospital. When it's made here, it puts the risk squarely on the patient.

QUESTION: Well except that you say when it's made here it is the choice of the doctor, the pharmacy or the hospital to seek that judgment early, isn't it. In other words in the -- the doctor could have gone ahead and prescribed Vioxx, and sent the bill in. The doctor could have kept the patient in the hospital another day, and sent the bill in. The insurance plan didn't

force an early decision. It gave an option of an early decision, so they would know where they stood.

MR. YOUNG: According to the documentation the HMO has, Your Honor, the two HMOs require that those decision be sought from them before or in the middle of treatment --

QUESTION: If you don't get it then, they automatically deny it later?

MR. YOUNG: It's not just that they could deny it, they -- there could be consequences to the provider. They could be deselected from the network, they could be told you're not going to get to see anymore of our patients.

QUESTION: So, they do force it. My premise was wrong.

MR. YOUNG: They do force it, Your Honor. And that's the reality.

QUESTION: Well, I really thought the train left the station in Pilot Life. I guess you don't agree with Pilot Life.

MR. YOUNG: Well no, Your Honor, we are not here to disagree with Pilot Life. Pilot Life works in the narrow circumstances in which it's been applied.

QUESTION: Well I thought that this was that circumstance of benefits.

MR. YOUNG: I was afraid you might. I was really afraid you might.

QUESTION: Yes.

MR. YOUNG: Then could we talk about Taylor a little

more, because that's really the complete branch --

(Laughing)

MR. YOUNG: I guess I come back to the Chief Justice's point which is we could have a situation where Pilot Life preemption could occur, but the Taylor holding is the one we're most concerned about, and here we are not trying to duplicate a claim that would be made under ERISA, under an ERISA duty.

And that leads me back to something else that's come up. The ERISA and it's regulations say nothing about setting a medical standard of care, when these medical judgments are made. That's an indication that it was left to the states, and should be left to the states. But this Court could certainly indicate, well this may still be preempted, but it shouldn't be removed to Federal court, under complete preemption doctrines.

QUESTION: Well how would that advance the general law at all? I mean, if the merits are decided against you, you know, I don't think we took this case to decide some question of removal jurisdiction, but I -- perhaps my colleagues don't agree with me.

MR. YOUNG: Well, that is the very narrow issue that in fact certiorari was granted on. And it is an issue that this Court last ruled on in the Anderson case last Term, and that case is illustrative of why complete preemption shouldn't apply here. There the majority found that the claim, while not citing to Federal usury law duplicated precisely and exactly Federal usury

law. And it was in essence, a Federal usury claim. Here our claim is not one for benefits. It couldn't be, there's no claim for benefits to be made. But more importantly we are not relying on a term --

QUESTION: It's a claim that depends on a denial of benefits, and isn't that the touchstone under Pilot?

MR. YOUNG: In fact Your Honor, you could have a situation where the medical necessity decision is made prospectively or concurrently and that's not a payment denial, in fact that's what we have in most circumstances of these kinds of cases.

QUESTION: But it is the predicate for payment denial, or a payment granted.

MR. YOUNG: Really Your Honor, in truth these decisions are never expressed by the utilization nurse at the hospital as a payment issue. She says you've got to go home now.

QUESTION: Well let's go back to my question -- I didn't mean to go off on a tangent. My question was, doesn't Pilot Life, turn on a determination which governs the payment or non payment of benefits?

MR. YOUNG: Yes, Your Honor. Here --

QUESTION: Then this it seems to me is such a determination.

MR. YOUNG: But here Your Honor, you could have a payment determination that complied completely with their internal document -- documents. Their definition of medical necessity,

what they say they will or won't do. And still violate the Texas standard for medical judgments and that's the problem.

QUESTION: It is indeed. That's why it's preempted. MR. YOUNG: Well --

QUESTION: You've described it very clearly.

MR. YOUNG: Well -- Your Honor, we're confusing remedies, and duties. The Texas duty is found no where in ERISA.

QUESTION: May I ask this question. Could you ever recover under the Texas statute without proving that you were entitled to have the benefit paid?

MR. YOUNG: It would not --

QUESTION: It wouldn't be phrased in those terms. Wouldn't it be part of -- wouldn't it be a necessary element of your claim, that part of what you're -- that you did have an entitlement to have that benefit paid.

MR. YOUNG: It would be an undisputed fact. It would be for example in these two cases. It's undisputed that Ruby Calad could get unlimited days in the hospital. The only issue is the medical judgment that she had to go home. Same with Mr. Davila. The medical judgment was that he would not get the Vioxx; he would get the cheaper generic drug. And --

QUESTION: But for you to prevail in Texas, it seems to me you have to be able to prove that they had a duty to pay for -- to provide him with the payment for Vioxx. But the statute says this, it says that it shall be a defense to any action that

one -- neither the health insurance carrier is -- didn't control the health care treatment decision. Which it wasn't here. And two, the health care insurance carrier did not deny or delay payment for any treatment prescribed, or recommended by a provider.

MR. YOUNG: But that doesn't -- that's --

QUESTION: So it is clearly a condition of recovery that you show that they were in violation of the ERISA plan.

MR. YOUNG: It's an affirmative defense they may be able to come in with. It's not a prerequisite to my case. CIGNA admits it is free.

QUESTION: Oh I see. Well that's a matter of who has to prove it. I mean if --

MR. YOUNG: But that's very important especially Your Honor when we're talking about a complete preemption issue. Is the Federal statute a prerequisite to my claim? All I have to prove and show Your Honor, is a medical judgment was exercised by a nurse, at CIGNA, or a physician or medical director at AETNA, and that they violated the Texas standard for those kinds of decisions.

QUESTION: As long as you frame it as an affirmative defense, rather as part of the cause of action, you can avoid preemption?

MR. YOUNG: No I'm not saying that Your Honor, but the gravamen of my case for purposes of looking at complete

preemption, the issue you were concerned about in Anderson, is what are the elements of my claim. They do not duplicate an ERISA claim, they don't even duplicate an ERISA duty. Now it may be at the end of the day Section 514 kicks in. We don't think it does for a lot of reasons, most importantly the insurance saving clause. Which clearly the Texas --

QUESTION: Which -- This is one item I meant to ask. On the other side they said that you never made any noises about the savings clause in the Fifth Circuit, that it entered the case just at this level, Is that so?

MR. YOUNG: No Your Honor, that's not correct. While it was not a feature argument with a heading in our briefing, we clearly pointed out to the Fifth Circuit the Moran decision by the Ninth Circuit, and that the Moran decision relied on the insurance saving clause. Then after oral argument --

QUESTION: That's in your brief before the Fifth Circuit?

MR. YOUNG: Yes it's a footnote in our brief. And then Your Honor, in -- after this Court decided Rush Prudential which occurred after oral argument in the Fifth Circuit, both sides submitted extensive letter briefs. And those are documents, 18 through 20 in the Fifth Circuit record that was recently transmitted to this Court, where both sides talked about what is the impact of Rush Prudential in terms of the insurance savings clause. But more important -- Thank you.

CHIEF JUSTICE: Thank you, Mr. Young.

Mr. Mattax we'll hear from you.

ORAL ARGUMENT OF DAVID C. MATTAX

FOR TEXAS, ET AL., AS AMICI CURIAE

MR. MATTAX: Mr. Chief Justice, and may it please the Court. The Texas legislature has imposed a duty of ordinary care on managed care entities that insert themselves into health care treatment decisions by exercising medical judgment to decide medical necessity. It is important to recognize at the outset as this court recognized the managed care entity is not the ERISA plan.

Our statute does not impose liability on the ERISA plan. Our statute does not impose liability on an employer. As Mr. Estrada said in his argument, the whole point of the complete preemption and the exclusive remedies provision Section 502(a), is insuring employers that will have limited liabilities. Our statute explicitly excludes employers from liability. And therefore the concerns of Section 502(a) are not at play in the Texas statute. The reason the Texas statute was passed was because managed care entities, HMOs and other varieties and forms, had decided to exercise medical judgment. And it is that duty that the state is regulating. Which is what I think distinguishes this case from Pilot Life. Going back and looking --

QUESTION: How does it distinguish it from Pilot Life? I

mean Pilot Life is talking about the insurance part, wasn't it.

MR. MATTAX: Yes, Chief Justice.

QUESTION: And then they said that even though apparently on it's face had to do with insurance and you'd think it would have been taken out, it wasn't taken out because of the fact that it interfered with the basic purposes of the act.

MR. MATTAX: Pilot Life was based on the Court's complete preemption decision in Allis-Chalmers versus Lueck.

QUESTION: Uh-huh.

MR. MATTAX: And in that case the Court recognized that the tort claim that was being alleged was derived from the general proposition to perform contracts in good faith. And the duty that the Court was looking at in Allis-Chalmers, and also Pilot Life, was the duty to enforce the contract that was the ERISA plan therefore implicating complete preemption. However the Court explicitly said in Allis-Chalmers, that Congress did not intend to give the substance of provisions the force of Federal law, ousting any inconsistent state regulations, because such a rule would allow labor unions, and unionized employees the power to exempt themselves from whatever state labor standards they disfavored. And again the Texas statute is not imposing any duty on the plan.

QUESTION: Yes, but is it not true that in order to recover under the Texas statute, not only do you have to prove a violation of the duty to use the due care and so forth. But you

also have to prove a violation of the plan?

MR. MATTAX: No I disagree. The revision in the act is setup such that if a managed care entity were to come in and say well I did not exercise any medical judgment, or I did not make any decisions that affected the treatment, they could come in as a defense and say, the reason I did not make any medical judgment was because the plan did not allow me to. The plan simply excluded that completely in a pure eligibility decision in the court's words in Pegram. So the cause of action that's alleged in the state statute is that particular managed care entity, exercised medical judgment. And that medical judgment resulted in an injury to me, and I think --

QUESTION: But it's also a defense that I did not fail to make any delay, I did not delay or fail to make any payment due.

MR. MATTAX: And if --

QUESTION: Isn't that a defense?

MR. MATTAX: The statute provides that as a defense. Again to make a reflection of, to show that in that particular case, I as a managed care entity did not exercise any medical judgments, because that's the defense --

QUESTION: But you make a medical judgment when you refuse to make a payment. You're deciding it's not medically necessary.

MR. MATTAX: Correct. And if they're making a decision

with regards to medical judgment. And they are exercising that judgment not according to our standard here. We are imposing that on the managed care entity.

QUESTION: No you're not. You're saying even if it's not according to your standard of care, if it is not due under the plan you're not liable.

MR. MATTAX: And what I'm saying there is --

QUESTION: Have you said that?

MR. MATTAX: That is a defense to the claim. And under this Court's decision in Caterpillar versus Williams a defense being raised to a claim does not create complete preemption.

QUESTION: Back to Pilot Life. In my understanding of the case, maybe I've got this wrong. Tell me if I do. There's a plan that says, an ERISA plan says we pay you for a treatment that's medically necessary. Then there's a person, it may be an insurance company, it may be a doctor, maybe somebody says it isn't medically necessary. The Plaintiff thinks it is medically necessary, so the question is whether the plan did what it said. Now you have a way of -- I mean isn't that what this is about?

MR. MATTAX: There's separate duties involved here. There is a duty under the plan, and the beneficiary can go to the plan and say because you hired this managed care entity to make this judgment, I would like to get the benefits under the plan and that would be a claim against the benefit plan. What Texas has done has said, when a managed care entity, an HMO goes and

sells his products to a plan, or goes and sells its services to a plan and is going to exercise medical judgment, then the state of Texas will regulate the exercises of that medical judgment of that managed care entity.

QUESTION: It's not just an HMO, it's also a health insurance carrier. Here, AETNA.

MR. MATTAX: It is theoretically anyone who exercises medical judgment that influences care. But I think it is important to recognize that the reasons for managed care as stated by both the Petitioners here, and I would briefly quote from a CIGNA brief, page 44. Utilization, review techniques are designed to ensure that quality care is delivered as cost efficiently as possible. The letter to Mr. Davila's doctor, specifically says - - this in AETNA's petition or Appendix 88 - - as part of our commitment to provide access to quality care. What the Court needs to recognize if I may, is that prior to the rise of managed care, decisions were made on a retrospective basis. An insurer would say, well we've looked at this, we do not believe it was medically necessary, we're not going to pay for it. The difference now is, managed care has taken on the rubric of saying, we will manage care, we will determine what is best for the patient and we will do that by dictating what is going to be paid for, and not paid for.

QUESTION: But it's just -- even at the early stage, it's simply a statement, we will not pay for it. That doesn't

mean that the patient can't do it other ways. It just means that this particular program won't pay for it.

MR. MATTAX: Well respectfully the statement is we don't think it's good for you. We don't think this care is appropriate for your particular situation. And there's no reason --

QUESTION: Well isn't it more a question of medical necessity. That is the plan says, all right, we'll cover it in case of medical necessity, and the plan says we don't think there's medical necessity here.

MR. MATTAX: Well the plan itself can put in the term medical necessity, but the plan is not making the determination of whether it's medically necessary or not. They have hired someone to make that determination for them. They may --

QUESTION: Well then it's certainly it's by the plan. I mean the fact that an agent makes it rather than the plan doesn't make any difference.

MR. MATTAX: But the reason to make that decision is because the medical necessity decision is a result of a determination by that managed care entity that they are going to manage the care that's provided. Again the letter that was sent --

QUESTION: Well how much does that advance the argument. I mean it's still a decision we won't pay for it.

MR. MATTAX: But the decision is based on a determination by a managed care entity that in their medical

judgment that the care is not necessary. And what Texas has said, with respect to that managed care entity. Again not the plan. Is that when you are going to exercise medical judgment and that is going to -- as a matter of practical reality, impact the care a patient receives and potentially cause damage to that patient, then we will regulate that as a separate duty, separate and apart from ERISA.

QUESTION: But you could say that in respect to any benefit of a plan. Let's imagine a plan with millions of different benefits. Whenever a benefit is turned down, there will always be a human being who told the plan manager it isn't called for. Now a state could come in and regulate their human being, those human beings in their capacity as professionals and say whenever they make such a mistake, they've made a professional misjudgment and we give you an extra remedy here. And that seems to be the thing that this statute forbids. I don't see how to get around it. I'd like you to tell me how to get around it. But I don't see it at the moment.

MR. MATTAX: And I believe the answer to that question is what the statute is concerned about is limiting and defining the liability of employers and plan sponsors. And a statute that regulates the conduct of a third party who sells their services to that plan or plan sponsor, has no impact on the liability of that plan or that plan sponsor. And in this particular case, in Texas we have made a determination that with managed care

entities as an entity, be it an HMO, be it a PPO, exercising medical judgment, we are regulating the medical judgment of that third party.

QUESTION: You really don't think -- well never mind.

CHIEF JUSTICE REHNQUIST: Thank you Mr. Mattax.

MR. MATTAX: Thank you.

CHIEF JUSTICE REHNQUIST: Mr. Estrada, you have three minutes remaining.

REBUTTAL ARGUMENT OF MIGUEL A. ESTRADA

ON BEHALF OF THE PETITIONERS

QUESTION: Mr. Estrada, you can address what you would like but there are three points that have come up during the Respondent's presentation that I'd be interested with a response to.

Number one, is it true that the people who make the decisions for your client must be medical doctors in Texas?

MR. ESTRADA: Well it is true by virtue of DOL regulations which provide that no claim may be turned down, without input from a medical professional in the relevant area.

QUESTION: My other two points are, what is your response to the point that the plan is not liable under Texas law --

MR. ESTRADA: Well --

QUESTION: -- just the insurance company here.

MR. ESTRADA: That was going to be one of my points --

QUESTION: Just so you can --

MR. ESTRADA: That is consistent with every case, from Pilot Life, Taylor, and Ingersoll Rand. Because in each of those cases, you were dealing with an insurance company that was acting as a claim administrator or insurer with respect to an ERISA plan. And if memory serves, the claim was made as well in Pegram, and the Court dealt with at the top of page 223 of 530 US. by pointing out that a contract between an HMO and the plan may itself contain elements of a plan to the extent that it governs the circumstances under which benefits may be obtained.

QUESTION: Lastly. Is there anything to the notion that there is no preemption when the interference with the plan, if there is any, only comes by way of an affirmative defense.

MR. ESTRADA: No and in fact it is also not true in this case that that's so. Because you have been citing subsection (c)(2) of the statute, here under Section (d) it is affirmatively stated that nothing in the act shall be construed to provide -- to require the provision of something that is not covered and that is at page -- also 59 (a) of the AETNA.

Just let me take one second to make two points. It is of course open to Texas to have a law that regulates the practice of medicine, by telling hospitals do not discharge somebody who needs care. And there is nothing in the Federal statute that would keep them from doing that. In fact we have a Federal statute in PAPA that does something similar with respect to

hospitals that take in medicare money. With respect to how quickly we could do these things Justice Stevens, the DOL regulations say that consistent with the urgency of the situation it must be done as soon as possible. It can be done informally and the doctor may act for the patient to pursue all of the plan appeals and that is at pages 17(a) and 3(a) of the Appendix to the blue brief.

Brief word about the insurance savings clause, I will not belabor it. There is a footnote in one of the briefs in the Court of Appeals. It doesn't raise the clause as opposed to the section 502 issue, but the acid test is that there was no mention of the clause, in the brief in opposition. Under this Court's rules and Oklahoma City versus Tuttle that is completely reclusive. Should we need to reach it I will point out that one of the response -- the petitioners in this case is a self funded plan, in the CIGNA case, which would be saved by the Deemer clause even if the insurance clause did apply in this case. And that is to both of them, the question whether the insurance savings clause does apply was conclusively resolved by Pilot Life, has never been revisited by the Court, and that Pilot Life --

Thank you Mr. Chief Justice.

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Estrada. The case is submitted.

(Whereupon, at 12:10 p.m., the case in the above-

entitled matter was submitted)